TENNESSEE DEPARTMENT OF HEALTH

JOINT ANNUAL REPORT OF HOSPITALS

2006

State ID _____

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SCHEDULE A - IDENTIFICATION

1. Name of Hospital _____ Federal Tax I.D. # _____
   Did your facility name change during the reporting period? ◉ YES ◉ NO
   County _____
2. Address of Facility Street _____
   City _____ State _____ Zip _____
3. Telephone Number _____
   Area Code Number
4. Name of Chief Executive Officer _____ _____
   First Name Last Name
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion _____
   Telephone Number if different than above _____
   Area Code Number
6. _____ Office Use Only
7. Reporting period used for this facility:
   Beginning Date _____ Ending Date _____
8. _____ Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ◉ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	◉	◉	◉
2			☐	◉	◉	◉
3			☐	◉	◉	◉
4			☐	◉	◉	◉
5			☐	◉	◉	◉

SCHEDULE B - CLASSIFICATION State ID _____

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
◎ 11 State	◎ 17 Armed Forces	◎ 20 Church-operated	◎ 23 Individual
◎ 12 County	◎ 18 Veterans Admin.	◎ 21 Other Nonprofit Corporation	◎ 24 Partnership
◎ 13 City	◎ 19 Other, please specify	◎ 22 Other not-for-profit, please specify	◎ 25 Corporation
◎ 14 City-County			
◎ 15 Hospital district or authority			

B. Is the hospital part of a health system? ◎ YES ◎ NO

If YES, please provide the name and location of the health system.

Name _____ City _____ State _____

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ◎ YES ◎ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

_____

E. Is the hospital a division of a holding company? ◎ YES ◎ NO

F. Does the hospital itself operate subsidiary corporations? ◎ YES ◎ NO

G. Is the hospital managed under contract? ◎ YES ◎ NO If YES, length of contract From _____ To _____

If YES, please provide name, city, and state of the organization that manages the hospital.

Name _____ City _____ State _____

Name _____ City _____ State _____

H. Is the hospital part of a health care alliance? ◎ YES ◎ NO (see definition of alliance)

If YES, please provide the name, city, and state of the alliance headquarters.

Name _____ City _____ State _____

Name _____ City _____ State _____

I. Is the hospital part of a health network? ◎ YES ◎ NO (see definition of network)

If YES, please provide the the name, city, and state of the network.

Name _____ City _____ State _____

Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

◎ 01 General medical and surgical	◎ 07 Rehabilitation
◎ 02 Pediatric	◎ 08 Orthopedic
◎ 03 Psychiatric	◎ 09 Chronic disease
◎ 04 Tuberculosis and other respiratory diseases	◎ 10 Alcoholism and other chemical dependency
◎ 05 Obstetrics and gynecology	◎ 11 Long term acute care
◎ 06 Eye, ear, nose and throat	◎ 12 Other-specify treatment area

_____

B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	◉	◉	◉	◉		
2. Group Practice Without Walls	◉	◉	◉	◉		
3. Open Panel Physician-Hospital Organization (PHO)	◉	◉	◉	◉		
4. Closed Panel Physician-Hospital Organization (PHO)	◉	◉	◉	◉		
5. Management Services Organization (MSO)	◉	◉	◉	◉		
6. Integrated Salary Model	◉	◉	◉	◉		
7. Equity Model	◉	◉	◉	◉		
8. Foundation	◉	◉	◉	◉		

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	(1) Your Hospital	(2) Hlth. System	(3) Hlth. Network	(4) Alliance	(5) Joint Venture With Insurer
A. Health Maintenance Organization	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
B. Preferred Provider Organization	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
C. Indemnity Fee For Service Plan	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ◉ NO
      1. How many do you contract with? _____
      2. Number of different contracts _____
   B. Preferred Provider Organization (PPO)? ◉ YES ◉ NO
      1. How many do you contract with? _____
      2. Number of different contracts _____

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". _____%

6. How many covered lives are in your capitation agreements? _____

SCHEDULE C - ACCREDITATIONS AND APPROVALS State ID _____

1. ACCREDITATIONS:

   A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
      Date of most recent accrediting letter or survey _____ ◉YES ◉NO
      If Yes, Is the hospital accredited under either/both of the following manuals:
      1. Comprehensive Accreditation Manual for Hospitals (CAMH) ◉YES ◉NO
      2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) ◉YES ◉NO
      3. Other manuals, please specify: _____
   B. Commission on Accreditation of Rehabilitation Facilities (CARF)
      Date of most recent accrediting letter or survey _____ ◉YES ◉NO
   C. American College of Surgeons Commission on Cancer ◉YES ◉NO

2. CERTIFICATIONS:

   Medicare Certification ◉YES ◉NO

3. OTHER:

   A. THA Membership ◉YES ◉NO
   B. Hospital Alliance of Tennessee, Inc. Membership ◉YES ◉NO
   C. American Hospital Association Membership ◉YES ◉NO
   D. American Medical Association Approval for Residencies (and Internships) ◉YES ◉NO
   E. State Approved School of Nursing:
      Registered Nurses ◉YES ◉NO
      Licensed Practical Nurses ◉YES ◉NO
   F. Medical School Affiliation ◉YES ◉NO
   G. Other, please specify _____
      Field is limited to 255 characters

SCHEDULE D - SERVICES State ID _____

1. CERTIFICATE OF NEED:

   Do you have an approved, **but not completed,** certificate of need (CON) ? ◉ YES ◉ NO

   If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval

2. Does your hospital own or operate Tennessee physician primary care clinics? ◉ YES ◉ NO If yes, how many? _____
   How many physicians practice in these clinics _____ ?

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ◉ YES ◉ NO If yes, how many? _____
   How many physicians practice in these clinics _____ ?

4. Does your hospital own or operate a blood bank? ◉ YES ◉ NO

5. Does your hospital own or operate an ambulance service? ◉ YES ◉ NO
   Please specify the counties where services are located:

   _____ _____ _____ _____ _____ _____

   Please specify the type of service and ownership relationship:

A. Land Transport	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
B. Helicopter	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
C. Special Neonatal Helicopter	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
D. Special Neonatal Land Transport	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture

SCHEDULE D - SERVICES (continued) State ID _____

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Clinic	County	City	State License #				
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Center	County	City	State License #				
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Center	County	City	State License #				
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Center	County	City	State License #				
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Center	County	City	State License #				
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture
				◯ own	◯ operate	◯ own and operate	◯ own in joint venture

SCHEDULE D - SERVICES (continued) State ID _____

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Hospice | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Hospice | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Facility | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Facility | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◯ NO If yes, please complete the following.

Name of Home | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Home | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

14. Does your hospital own or operate an urgent care center? ◯ YES ◯ NO If yes, please complete the following.

Name of Center | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Center | County | City | State License # ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

15. Does your hospital own a home health agency? ◯ YES ◯ NO

Name of Agency: _____
Location of Agency: City _____ County _____
State License Number of Agency _____
Number of Visits _____
◯ own ◯ operate

Name of Agency: _____
Location of Agency: City _____ County _____
State License Number of Agency _____
Number of Visits _____
◯ own ◯ operate

SCHEDULE D - SERVICES (continued) State ID _____

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ◯ YES ◯ NO
If yes, please complete the following.

Name of Home _____ County _____ City _____ State License # _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Number of Beds - Total 0 ; Medicare only (SNF) _____ ; Medicaid only (NF) _____ ; Medicare/Medicaid (SNF/NF) _____ ; Not Certified _____

Name of Home _____ County _____ City _____ State License # _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Number of Beds - Total 0 ; Medicare only (SNF) _____ ; Medicaid only (NF) _____ ; Medicare/Medicaid (SNF/NF) _____ ; Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ◯ YES ◯ NO If yes, please specify:

Name of SNF _____ State License # _____ Number of Licensed Beds _____ Number of Staffed Beds _____

Number of Admissions _____ Number of Patient Days _____

18. Does your hospital own or operate a mobile unit that operates in Tennessee? ◯ YES ◯ NO
If yes, specify name(s) and whether owned or operated.

A. List mobile services:

1 _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
2 _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
3 _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
4 _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1 _____ _____ _____
2 _____ _____ _____
3 _____ _____ _____
4 _____ _____ _____

19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	◉	◉	Procedures		Procedures	
Extracorporeal Shock Wave	◉	◉				
# of fixed units _____			Procedures		Procedures	
# of mobile units _____			Procedures		Procedures	
# of days per week _____						
Renal Dialysis						
# of beds _____						
# of outpatient stations _____						
# of stations _____						
Hemo Dialysis	◉	◉	Patients		Patients	
			Treatments		Treatments	
Peritoneal Dialysis	◉	◉	Patients		Patients	
			Treatments		Treatments	
B. Oncology:						
Chemotherapy	◉	◉	Patients		Patients	
					Encounters	
Hyperthermia	◉	◉	Treatments		Treatments	
Radiation Therapy-Megavoltage	◉	◉				
Unit 1			Patients		Patients	
Date Initiated _____			Treatments		Treatments	
Unit 2			Patients		Patients	
Date Initiated _____			Treatments		Treatments	
Unit 3			Patients		Patients	
Date Initiated _____			Treatments		Treatments	

SCHEDULE D - SERVICES (continued) State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic Scanners CT/CAT	◎	◎	Patients		Visits	
# of fixed units _____			Procedures		Procedures	
# of mobile units _____			Procedures		Procedures	
# of days per week _____						
Ultrafast CT	◎	◎	Patients		Visits	
# of fixed units _____			Procedures		Procedures	
# of mobile units _____			Procedures		Procedures	
# of days per week _____						
Magnetic Resonance Imaging	◎	◎				
# of fixed units _____			Procedures		Procedures	
# of mobile units _____			Procedures		Procedures	
# of days per week _____						
Nuclear Medicine	◎	◎	Procedures		Procedures	
Radium Therapy	◎	◎	Procedures		Procedures	
Isotope Therapy	◎	◎	Procedures		Procedures	
Positron Emission Tomography	◎	◎				
# of fixed units _____			Procedures		Procedures	
# of mobile units _____			Procedures		Procedures	
# of days per week _____						
Mammography	◎	◎	Procedures		Procedures	
# of ACR accredited units _____						
# of other fixed units _____						
# of mobile units _____						
# of days per week _____						

Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization Date Initiated _____ # labs _____						
Intra-Cardiac or Coronary Artery	◉	◉	Adult Procedures Pediatric Procedures	_____ _____	Adult Procedures Pediatric Procedures	_____ _____
Percutaneous Transluminal Coronary Angioplasty	◉	◉	Adult Procedures Pediatric Procedures	_____ _____	Adult Procedures Pediatric Procedures	_____ _____
Thrombolytic Therapy	◉	◉	Adult Procedures Pediatric Procedures	_____ _____	Adult Procedures Pediatric Procedures	_____ _____
Open Heart Surgery # dedicated O.R.'s _____	◉	◉	Adult Operations Pediatric Operations	_____ _____		
E. Surgery:						
Inpatient # operating rooms _____ # procedure rooms _____	◉	◉	Patients Procedures Procedures	_____ _____ _____		
Outpatient (one day) # dedicated O.R.'s _____ # procedure rooms _____	◉	◉			Patients Procedures Procedures	_____ _____ _____
F. Rehabilitation						
Cardiac	◉	◉	Patients	_____	Patients	_____

SCHEDULE D - SERVICES (continued) State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency	◎	◎	Patients		Patients Visits	
Nutritional Counseling	◎	◎	Patients		Patients Visits	
Pulmonary	◎	◎	Patients		Patients Visits	
G. Physical Rehabilitation:						
Occupational Therapy	◎	◎	Patients		Patients Visits	
Orthotic Services	◎	◎	Patients		Patients Visits	
Physical Therapy	◎	◎	Patients		Patients Visits	
Prosthetic Services	◎	◎	Patients		Patients Visits	
Speech/Language Therapy	◎	◎	Patients		Patients Visits	
Therapeutic Recreational Service	◎	◎	Patients		Patients Visits	

Do you have a dedicated inpatient physical rehabilitation unit? ◎ YES ◎ NO

If yes, number of assigned beds. _____ # of admissions _____ # of pt. days _____

Do you have a dedicated outpatient physical rehabilitation unit? ◎ YES ◎ NO

SCHEDULE D - SERVICES (continued) State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
H. Obstetrics/Newborn:						
Perinatal Level of Care						
Level I	◉	◉				
Level II - A	◉	◉				
Level II - B	◉	◉				
Level III	◉	◉				
Cesarean Section	◉	◉	Deliveries	_____		
Birthing Rooms	◉	◉	Deliveries	_____		
# rooms _____						
# LDRP beds _____						
# LDR beds _____						
Labor Rooms	◉	◉				
# rooms _____						
Postpartum Services	◉	◉	Patients	_____	Visits	_____
# beds _____						
Newborn Nursery	◉	◉	Infants Discharged	_____		
# bassinets _____			Pt. Days	_____		
Premature Nursery	◉	◉	Infants Discharged	_____		
# bassinets _____			Pt. Days	_____		
Isolation Nursery	◉	◉	Pt. Days	_____		
# bassinets _____						

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Transplants:						
Organs						
Total Donors			Donors			
Total Harvested	◎	◎	Donations			
Transplants	◎	◎	Transplants			
Organ Bank	◎	◎	Organs			
Type of Organ:						
Heart	◎	◎	# Harvested			
			# Transplanted			
Liver	◎	◎	# Harvested			
			# Transplanted			
Kidneys	◎	◎	# Harvested			
			# Transplanted			
Pancreas	◎	◎	# Harvested			
			# Transplanted			
Intestine	◎	◎	# Harvested			
			# Transplanted			
Any Other _____	◎	◎	# Harvested			
			# Transplanted			
Tissues						
Total Donors			Donors			
Total Harvested	◎	◎	Donations			
Transplants	◎	◎	Transplants			
Tissue Bank	◎	◎	Tissues			
Type of Tissue:						
Eye	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Bone	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Bone Marrow	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Connective	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Cardiovascular	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Stem Cell	◎	◎	# Harvested			
			# Transplanted		# Transplanted	
Other _____	◎	◎	# Harvested			
			# Transplanted		# Transplanted	

SCHEDULE D - SERVICES (continued) State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Other:						
Hyperbaric Oxygen Therapy	◎	◎	Patients			
Gamma Knife	◎	◎	Patients		Patients	
K. Intensive/Intermediate:						
Burn Care Unit	◎	◎	Patients		Patients	
# beds			Pt. Days			
Cardiac Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Medical Intensive Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Mixed Intensive Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Neonatal Intensive Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Neonatal Intermediate Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Pediatric Care Unit	◎	◎	Patients			
# beds			Pt. Days			
Stepdown ICU	◎	◎	Patients			
# beds			Pt. Days			
Stepdown CCU	◎	◎	Patients			
# beds			Pt. Days			
Surgical Intensive Care Unit	◎	◎	Patients			
# beds			Pt. Days			

SCHEDULE D - SERVICES (continued) State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Intensive/Intermediate (continued):						
Other, specify _____ # of beds _____	◉	◉	Patients Pt. Days	_____ _____		
Other, specify _____ # of beds _____	◉	◉	Patients Pt. Days	_____ _____		
L. Electroconvulsive Treatment	◉	◉	Patients Treatments	_____ _____	Patients Treatments	_____ _____
M. Other Convulsive Treatment	◉	◉	Patients Treatments	_____ _____	Patients Treatments	_____ _____

N. 23 Hour Observation ◉ YES ◉ NO Outpatients _____

O. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? _____
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? _____
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? _____

SCHEDULE E - FINANCIAL DATA State ID _____

Dates covered from _____ to _____ Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)		-		=	
1) Medicare Managed Care - Inpatient		-		=	
b) Medicare Outpatient - Total (include managed care)		-		=	
1) Medicare Managed Care - Outpatient		-		=	
c) Medicaid/TennCare Inpatient* (for EAH use 5.b.2.)		-		=	
d) Medicaid/TennCare Outpatient* (for EAH use 5.b.2.)		-		=	
e) Other		-		=	
f) Total government sources		-		=	
2. Nongovernment * see instructions					
a) Self-Pay		-		=	
b) Blue Cross Blue Shield - Total		-		=	
1) Indemnity		-		=	
2) HMO/POS		-		=	
3) PPO		-		=	
c) Commercial Insurers - Total (excludes Workers Comp)		-		=	
1) Indemnity		-		=	
2) HMO/POS		-		=	
3) PPO		-		=	
d) Workers Compensation		-		=	
e) Other		-		=	
f) Total nongovernment sources		-		=	
3. Totals			must agree with 4k below		
a) Total Inpatient (excl. Newborn)					
b) Newborns					
c) Total Inpatient (incl. Newborn) (3a + 3b)		-		=	
d) Total Outpatient		-		=	
e) Grand Total (1f + 2f)		-		=	

4. Nongovernment Adjustments to Charges

a) Nongovernment Contractual			
b) Bad Debt - Inpatient			
c) Bad Debt - Outpatient			
d) Charity Care - Inpatient		Total Bad Debt	
e) Charity Care - Outpatient			
f) Medically Indigent - Low Income - Inpatient		Total Charity	
g) Medically Indigent - Low Income - Outpatient			Total Charity plus Medically Indigent
h) Medically Indigent - Other - Inpatient			
i) Medically Indigent - Other - Outpatient			
j) Other Adjustments, specify types: _____		Total Medically Indigent	Total Charity & Medically Indigent & Bad Debt
k) Total Nongovernment Adjustments			
l) Portion of bad debt, charity, medically indigent adjustment due to uninsured patients			

SCHEDULE E - FINANCIAL DATA (continued) State ID _____

A. CHARGES (continued)

5. Other operating revenue

a) Tax appropriations . . . . . _____

b) State and Local government contributions:

1) Amount designated to offset indigent care . . . . _____

2) Essential Access Hospital (EAH) payments . . _____

3) Critical Access Hospital (CAH) payments . . . . _____

4) Amount used for other . . . . . _____

5) Total . . . . . _____

c) Other contributions:

1) Amount designated to offset indigent care . . . . _____

2) Amount used for other . . . . . _____

3) Total . . . . . _____

d) Other (include cafeteria, gift shop, etc.) . . . . . _____

e) Total other operating revenue . . . . . _____
[a + b5 + c3 + d]

6. Nonoperating revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions . . . . . _____

b) Grants . . . . . _____

c) Interest Income . . . . . _____

d) Other . . . . . _____

e) Total nonoperating revenue . . . . . _____
[Add a through d]

f) Total revenue . . . . . _____
[Net Patient Revenue
[3e + 5e + 6e]]

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries) . . . . . _____

b) Medical and dental residents (include medical and dental interns) . . . . . _____

c) Trainees (medical technology, x-ray therapy, administrative, and so forth) . . . . . _____

d) Registered and licensed practical nurses . . . . . _____

e) All other personnel . . . . . _____

f) TOTAL PAYROLL EXPENSES . . . . . _____
(add a through e)

2. Nonpayroll expenses

a) Employee benefits (social security, group insurance, retirement benefits) . . . . . _____

b) Professional fees (medical, dental, legal, auditing, consultant and so forth.) . . . . . _____

c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies.) . . . . . _____

d) Depreciation expense . . . . . _____

e) Interest expense . . . . . _____

f) Energy expense . . . . . _____

g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth.) . . . . . _____

h) Total nonpayroll expenses: (add a through g) . . . . . _____

i) TOTAL EXPENSES (add 1f + 2h) . . . . . _____

B. 3. Are system overhead/management fees included in your expenses? If yes, specify amount. _____

C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? _____

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased)

1. Gross plant and equipment assets (including land, building, and equipment). _____
2. LESS: Deduction for accumulated depreciation _____
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) _____

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets)
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.)
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? _____

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? _____
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? _____

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? _____
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.)

K. 1. Federal Income Tax: _____

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility _____
   b) Taxes on all Other Property _____

3. Other Local, State, or Federal Taxes: (exclude sales tax) _____

L. Does your hospital bill include charges incurred for the following professional services?

Radiology - ◯ YES ◯ NO Pathology - ◯ YES ◯ NO Anesthesiology - ◯ YES ◯ NO Other - Specify _____

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
PHP				
Blue Care				
John Deere (Heritage)				
TennCare Select				
TLC				
Ominicare				
VHP				
Better Health Plans				
TennCare, MCO				
BHO				
TBH				
Premier				

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
PHP				
Blue Care				
John Deere (Heritage)				
TennCare Select				
TLC				
Ominicare				
VHP				
Better Health Plans				
TennCare, MCO				
BHO				
TBH				
Premier				

SCHEDULE F - BEDS AND BASSINETS State ID _____

1. AS OF THE LAST DAY OF THE REPORTING PERIOD PLEASE GIVE THE NUMBER OF:

   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS (exclude beds in a sub-acute unit that are licensed as nursing home beds) _____
   B. Average # of staffed beds in use over the course of the reporting period. _____
   C. NEWBORN NURSERY BASSINETS _____
   D. Licensed Beds that were not staffed at all during the reporting period. _____

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period?
   ◉ YES ◉ NO If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

   Bed change (+ or -) _____ Bed change (+ or -) _____ Bed change (+ or -) _____ Bed change (+ or -) _____
   Date: _____ Date: _____ Date: _____ Date: _____

3 SWING BEDS:

   A. Does your facility utilize swing beds? ◉ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. _____

   B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

   (How many admissions and how many days did you provide in the following categories)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay		
Other		
Total		

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial		
Blue Cross		
Medicare		
Private Pay		
Other		
Total		

4. A. Number of Beds Set up and Staffed on September 30th

SERVICE	BEDS
Medical	
Surgical	
Medical/Surgical	
Obstetrics	
Gynecological	
OB/GYN	
Pediatric	
Eye	
Neonatal Intensive Care	
Neonatal Intermediate Care	
Intensive Care (excluding Neonatal)	
Orthopedic	
Urology	
Rehabilitation	
Chronic/Extended Care	
Pulmonary	
Psychiatric	
Psychiatric specifically for Children and Youth under age 18	
Psychiatric specifically for Geriatric Patients	
Chemical Dependency	
Chemical Dependency specifically for Children and Youth under age 18	
Chemical Dependency specifically for Geriatric Patients	
Swing Beds (for long term skilled or intermediate care)	
Other, specify	
Unassigned	
TOTAL	0

B. Number of Patients in hospital on 9/30 (exclude normal newborns coded as DRG 390 or 391, and a Primary diagnosis code of V30 through V39, long term skilled or intermediate patient(s) _____

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ◯ YES ◯ NO If yes, # of beds _____

B. Do you have beds assigned to dedicated 23-hour observation unit? ◯ YES ◯ NO If yes, # of beds _____

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ◯ YES ◯ NO
If yes, # of beds _____

SCHEDULE G-UTILIZATION State ID _____

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ◉
   or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System		
02 Eye		
03 Ear, Nose, Mouth and Throat		
04 Respiratory System		
05 Circulatory System		
06 Digestive System		
07 Hepatobiliary System & Pancreas		
08 Musculoskeletal Sys. & Connective Tissue		
09 Skin, Subcutaneous Tissue & Breast		
10 Endocrine, Nutritional & Metabolic		
11 Kidney & Urinary Tract		
12 Male Reproductive System		
13 Female Reproductive System		
14 Pregnancy, Childbirth & the Puerperium		
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period		
16 Blood and Blood Forming Organs and Immunological Disorders		
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms		
18 Infectious & Parasitic Diseases		
19 Mental Diseases & Disorders		
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders		
21 Injuries, Poisoning, & Toxic Effects of Drugs		
22 Burns		
23 Factors Influencing Health Status and Other Contacts with Health Services		
24 Multiple Significant Trauma		
25 Human Immunodeficiency Virus Infections		
Other DRGs Associated with All MDCs		
TOTAL		

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns coded as DRG 390 or 391, and a primary diagnosis code of V30 through V39)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Self Pay			
Blue Cross/Blue Shield - Total			
HMO/POS			
Indemnity			
PPO			
Champus			
Commercial Insurance - Total (excludes Workers Comp)			
HMO/POS			
Indemnity			
PPO			
Medicaid/Tenncare			
Medicare - Total			
Medicare Managed Care			
Workers Compensation			
Other			
Total			

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns coded as DRG 390 or 391, and a primary diagnosis code of V30 through V39)

Please indicate whether you are reporting Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years			
15-17 years			
18-64 years			
65-74 years			
75-84 years			
85 years & older			
GRAND TOTAL			

* Should include emergency department visits and hospital outpatient visits

5. PATIENT ORIGIN (excluding normal newborns coded as DRG 390 or 391, and a primary diagnosis code of V30 through V39)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have less than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson		
02	Bedford		
03	Benton		
04	Bledsoe		
05	Blount		
06	Bradley		
07	Campbell		
08	Cannon		
09	Carroll		
10	Carter		
11	Cheatham		
12	Chester		
13	Claiborne		
14	Clay		
15	Cocke		
16	Coffee		
17	Crockett		
18	Cumberland		
19	Davidson		
20	Decatur		
21	Dekalb		
22	Dickson		
23	Dyer		
24	Fayette		
25	Fentress		
26	Franklin		
27	Gibson		
28	Giles		

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger		
30	Greene		
31	Grundy		
32	Hamblen		
33	Hamilton		
34	Hancock		
35	Hardeman		
36	Hardin		
37	Hawkins		
38	Haywood		
39	Henderson		
40	Henry		
41	Hickman		
42	Houston		
43	Humphreys		
44	Jackson		
45	Jefferson		
46	Johnson		
47	Knox		
48	Lake		
49	Lauderdale		
50	Lawrence		
51	Lewis		
52	Lincoln		
53	Loudon		
54	McMinn		
55	McNairy		
56	Macon		
57	Madison		
58	Marion		
59	Marshall		
60	Maury		
61	Meigs		
62	Monroe		

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery		
64	Moore		
65	Morgan		
66	Obion		
67	Overton		
68	Perry		
69	Pickett		
70	Polk		
71	Putnam		
72	Rhea		
73	Roane		
74	Robertson		
75	Rutherford		
76	Scott		
77	Sequatchie		
78	Sevier		
79	Shelby		
80	Smith		
81	Stewart		
82	Sullivan		
83	Sumner		
84	Tipton		
85	Trousdale		
86	Unicoi		
87	Union		
88	Van Buren		
89	Warren		
90	Washington		
91	Wayne		
92	Weakley		
93	White		
94	Williamson		
95	Wilson		
96	TN County Unknown		
	Tennessee Total		

5. PATIENT ORIGIN (continued)

	State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
	ALABAMA COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Alabama Total		
	GEORGIA COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Georgia Total		
	MISSISSIPPI COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Mississippi Total		
	ARKANSAS COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Arkansas Total		
	MISSOURI COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Missouri Total		

5. PATIENT ORIGIN (continued)

	State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
	KENTUCKY COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Kentucky Total		
	VIRGINIA COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	Virginia Total		
	NORTH CAROLINA COUNTIES:		
	(Specify)		
	1)		
	2)		
	3)		
	North Carolina Total		
	OTHER STATES:		
	(Specify)		
	1)		
	2)		
	3)		
	RESIDENCE UNKNOWN:		
	GRAND TOTAL		

6. PATIENT ORIGIN FOR CHARITY/MEDICALLY INDIGENT PATIENTS
(excluding normal newborns coded as DRG 390 or 391, and a primary diagnosis code of V30 through V39)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ◉

County #	Tennessee County of Residence	Gross Charges	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson			
02	Bedford			
03	Benton			
04	Bledsoe			
05	Blount			
06	Bradley			
07	Campbell			
08	Cannon			
09	Carroll			
10	Carter			
11	Cheatham			
12	Chester			
13	Claiborne			
14	Clay			
15	Cocke			
16	Coffee			
17	Crockett			
18	Cumberland			
19	Davidson			
20	Decatur			
21	Dekalb			
22	Dickson			
23	Dyer			
34	Fayette			
25	Fentress			
26	Franklin			
27	Gibson			
28	Giles			

6. PATIENT ORIGIN FOR CHARITY/MEDICALLY INDIGENT PATIENTS (continued)

County #	Tennessee County of Residence	Gross Charges	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger			
30	Greene			
31	Grundy			
32	Hamblen			
33	Hamilton			
34	Hancock			
35	Hardeman			
36	Hardin			
37	Hawkins			
38	Haywood			
39	Henderson			
40	Henry			
41	Hickman			
42	Houston			
43	Humphreys			
44	Jackson			
45	Jefferson			
46	Johnson			
47	Knox			
48	Lake			
49	Lauderdale			
50	Lawrence			
51	Lewis			
52	Lincoln			
53	Loudon			
54	McMinn			
55	McNairy			
56	Macon			
57	Madison			
58	Marion			
59	Marshall			
60	Maury			
61	Meigs			
62	Monroe			
63	Montgomery			

6. PATIENT ORIGIN FOR CHARITY/MEDICALLY INDIGENT PATIENTS (continued)

County #	Tennessee County of Residence	Gross Charges	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
64	Moore			
65	Morgan			
66	Obion			
67	Overton			
68	Perry			
69	Pickett			
70	Polk			
71	Putnam			
72	Rhea			
73	Roane			
74	Robertson			
75	Rutherford			
76	Scott			
77	Sequatchie			
78	Sevier			
79	Shelby			
80	Smith			
81	Stewart			
82	Sullivan			
83	Sumner			
84	Tipton			
85	Trousdale			
86	Unicoi			
87	Union			
88	Van Buren			
89	Warren			
90	Washington			
91	Wayne			
92	Weakley			
93	White			
94	Williamson			
95	Wilson			
96	TN County Unknown			
	Tennessee Total			
	All Other States			
	GRAND TOTAL	$0	0	0

7. Delivery Status:

   A. Number of Infants Born Alive _____

   B. Number of Deaths of Infants Born Alive _____

   C. Number of Fetal Deaths (500 grams or more or in the absence of weight, 22 weeks or more gestation) _____

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS State ID _____

1. TYPE OF UNIT - PSYCHIATRIC:
   Do you have a dedicated psychiatric unit? ◯ YES ◯ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds. _____
   B. Date unit opened. _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◯ or
   Discharges and Discharge Patient Days. ◯

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17					
Adults Ages 18 - 64					
Elderly Ages 65 and older					
Total	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ◯ YES ◯ NO
   If yes, please specilfy name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◯ NO

6. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	OUTPATIENT CHARGES	TOTAL CHARGES	ADJUSTMENTS TO CHARGES	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:					
1. Self-Pay					
2. Blue-Cross/Blue Shield - Total					
HMO/POS					
Indemnity					
PPO					
3. Commercial - Total (excludes Workers Comp)					
HMO/POS					
Indemnity					
PPO					
4. Champus/TRICARE					
5. Medicaid/TennCare					
6. Medicare - Total					
7. Medicare Managed Care					
8. Workers Compensation					
9. Other					

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	
2. Charity Care/Medically Indigent	
3. Contractual Adjustments	
4. Total	
5. Portion of bad debt, charity, and medically indigent adjustments due to uninsured patients	

7. A. SERVICE CHARGES

1. Routine Treatment		
2. Ancillary Services		
3. Other		
4. Total		

B. Do these charges include physicians' fees? ◉ YES ◉ NO

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued) State ID _____

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ◯ YES ◯ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds. _____
   B. Date unit opened. _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◯ or
   Discharges and Discharge Patient Days. ◯

	Inpatient			Partial Care	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17						
Adults Ages 18 - 64						
Elderly Ages 65 and older						
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ◯ YES ◯ NO
   If yes, please specilfy name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◯ NO

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	OUTPATIENT CHARGES	TOTAL CHARGES	ADJUSTMENTS TO CHARGES	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:					
1. Self-Pay					
2. Blue-Cross/Blue Shield - Total					
HMO/POS					
Indemnity					
PPO					
3. Commercial - Total (excludes Workers Comp)					
HMO/POS					
Indemnity					
PPO					
4. Champus/TRICARE					
5. Medicaid/TennCare					
6. Medicare - Total					
7. Medicare Managed Care					
8. Workers Compensation					
9. Other					
B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE					
1. Bad Debt					
2. Charity Care/Medically Indigent					
3. Contractual Adjustments					
4. Total					
5. Portion of bad debt, charity, and medically indigent adjustments due to uninsured patients					

7. A. SERVICE CHARGES

1. Routine Treatment		
2. Ancillary Services		
3. Other		
4. Total		

B. Do these charges include physicians' fees? ◉ YES ◉ NO

SCHEDULE I - EMERGENCY DEPARTMENT State ID _____

1. What is the direct telephone number into your Emergency Department? _____

2. Is the Emergency Department managed under a management contract different from the hospital itself? ◉ YES ◉ NO
   If so, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

TennCare		BCBS		Grand Total	
PHP		BC/BS HMO/POS			
Blue Care		BC/BS PPO			
John Deere (Heritage)		BC/BS Indemnity			
TennCare Select		BCBS Total			
TLC		Commercial			
Omnicare		HMO/POS			
VHP		PPO			
Better Health Plans		Indemnity			
TennCare, MCO Unspecified		Commercial Total			
TBH		Medicare			
Premier		Medicare Mgd. Care			
TennCare Total		Medicare Total			
		Self Pay			
		All Other			

4. Is your emergency Department staffed 24 hours per day? ◉ YES ◉ NO If no, please give hours covered. ____

5. Indicate the number of the following personnel which are available in the hospital and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine		
Board eligible in Emergency Medicine		
Declared Speciality of Emergency Medicine		
Other Physicians Available to Emergency Department		
Board Certified Psychiatrists		
B. NURSES:		
Nurse Practitioners		
R.N.'s with formal emergency training and experience		
Other R.N.'s		
L.P.N.'s and other nursing support personnel		
Clerical Staff		
C. OTHER:		
E.M.T.		
E.M.T. advanced		

SCHEDULE I - EMERGENCY DEPARTMENT (continued) State ID _____

6. Is your Emergency Department operated with a separate department status? ◎ YES ◎ NO

7. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	◎	◎
Ambulances	◎	◎
Other hospitals	◎	◎
B. HELIPORT:	◎	◎
C. PHARMACY IN ER:	◎	◎
D. BLOOD BANK:		
Fully stocked	◎	◎
Common blood types only	◎	◎
Blood expanders	◎	◎

8. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ◎ YES ◎ NO

B. Burns ◎ YES ◎ NO

Do you have a designation by a gov't. agency as a Burn Center? ◎ YES ◎ NO

C. Pediatrics ◎ YES ◎ NO

D. Other, specify

_____

9. Triage: Total number of patients who presented in your ER. _____

Total number treated in your ER. _____

Total number not treated in your ER but referred to physician or clinic for treatment. _____

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES State ID _____

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants			☐
B. Director, Health Services Research & Assistants			☐
C. Marketing & Planning Officer(s) & Assistants			☐
D. Financial and Accounting Officer(s) & Assistants			☐
2. Physician and Dental Services:			
A. Physicians			☐
B. Medical residents			☐
C. Dentists			☐
D. Dental residents			☐
3. Nursing Services:			
A. Registered Nurses			☐
B. LPNs			☐
C. Ancillary nursing personnel			☐
4. Certified Nurse Midwives			☐
5. Nurse Anesthetists			☐
6. Physicians assistants			☐
7. Nurse practitioners			☐
8. Medical record service:			
A. Medical record administrators			☐
B. Medical record technicians (certified or accredited)			☐
C. Other Medical record technicians			☐
9. Pharmacy:			
A. Pharmacists, licensed			☐
B. Pharmacy technicians			☐
C. Clinical Phar-D			☐
10. Clinical laboratory services:			
A. Medical Technologists			☐
B. Other laboratory personnel			☐
11. Dietary services:			
A. Dietitians			☐
B. Dietetic technicians			☐
12. Radiological services:			
A. Radiographers (radiologic technologists)			☐
B. Radiation therapy technologists			☐
C. Nuclear medicine technologists			☐
D. Other radiologic personnel			☐
13. Therapeutic services:			
A. Occupational therapists			☐
B. Occupational therapy assistants & aides			☐
C. Physical therapists			☐
D. Physical therapy assistants & aides			☐
E. Recreational therapists			☐
14. Speech and hearing services:			
A. Speech Pathologist			☐
B. Audiologist			☐
15. Respiratory therapy services:			
A. Respiratory therapists			☐
B. Respiratory therapy technicians			☐
16. Psychiatric services:			
A. Clinical psychologists			☐
B. Psychiatric social workers			☐
C. Psychiatric registered nurses			☐
D. Other mental health professionals			☐
17. Chemical dependency services:			
A. Clinical psychologists			☐
B. Social workers			☐
C. Registered nurses			☐
D. Other specialists in addiction and/or in chemical dependency			☐
18. Medical Social workers			☐
19. Surgical technicians			☐
20. All other certified professional & technical			☐
21. All other non-certified professional & technical			☐
22. All other personnel			☐
TOTAL	0.0	0.0	

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SCHEDULE K - MEDICAL STAFF

State ID _____

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice			
B. Pediatric			
C. General internal medicine			
D. Psychiatric			
E. Neonatologist			
F. Cardiologists			
G. Neurologists			
H. Other medical specialties			
2. SURGICAL SPECIALTIES:			
A. General surgery			
B. Obstetrics and gynecology			
C. Perinatologists			
D. Gynecology			
E. Orthopedic			
F. Neurosurgeons			
G. Cardiovascular			
H. Gastroenterology			
I. Other surgical specialties			
3. OTHER SPECIALTIES:			
A. Pathology			
B. Radiology			
C. Anesthesiology			
D. Other specialties			
4. DENTAL SPECIALTIES:			
TOTAL	0	0	0

SCHEDULE L - PERINATAL State ID _____

1A. Person completing Perinatal survey _____
1B. Telephone Number _____
1C. Fax Number _____

Please complete the following questions.

2. Births
   A. Total number of births _____
   B. Birth weight below 2500 grams (5lb 8oz) _____
   C. Birth weight below 1500 grams (3 lb 5oz) _____

3. Number of babies on ventilator longer than 24 hours _____

4. Number of babies received from referring hospitals for neonatal management _____

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	◎	◎
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	◎	◎
7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?		
a. OBSTETRICS:		
Perinatal Sonologist	◎	◎
Hematologist	◎	◎
Cardiologist	◎	◎
b. NEONATAL:		
Pediatric Radiologist	◎	◎
Pediatric Cardiologist	◎	◎
Pediatric Neurologist	◎	◎
Pathologist	◎	◎
Pediatric Surgeon	◎	◎

SCHEDULE M - SURVEY ON NURSING PERSONNEL State ID _____

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total						
Bachelors Degree						
Associate Degree						
Diploma						
Masters Degree						
Doctorate Degree						

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total						
Nurse Practitioner						
Clinical Nurse Specialist						
CRNA						
Certified Nurse Midwife						

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total		

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU				
ER				
Other (Specify):				

SCHEDULE N - HEALTH CARE PLANS ACCEPTED State ID _____

The Health Consumer Right-to-Know Act of 1998 which was signed by Governor Sunquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans: